STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	03/07/2019

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GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Mississippi State Department of Health on 3/4/19 - 3/7/19. The facility was found not to be in substantial compliance with requirements for Medicare and Medicaid participation. Deficiencies were cited at F656, F657, F677, F689, and F690. The census at the time of survey was 90 and the facility held a license for 103 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		4/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/11/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to implement comprehensive care plan interventions for two (2) of the 21 sampled residents, Resident #14 and Resident #42, whose care plans were reviewed. Resident #42 had a care plan for indwelling urinary catheter care that was to be done every shift and the care plan was not consistently implemented. Resident #14 had a care plan for nail care to be provided, which was not implemented. Findings include: Record review of the facility's policy titled, "Comprehensive Care Plans," dated September 2018, revealed the policy of the facility was to develop and implement a comprehensive person-centered care plan for each resident that	F 656	1.The Medicare Coordinator provided nail care for Resident #14 on 3/6/19. Resident # 42 did not develop an infection as a result of inconsistent foley catheter care.Resident # 42 was assessed on 4/7/19 by the Director of Nursing for signs and symptoms of infection, Resident #42 did not exhibit signs or symptoms of infection. Resident #42 s foley catheter was discontinued on 3/22/19. 2.All residents have the potential to be affected. 3.All licensed nurses and Certified Nursing Assistants were in-serviced by the Director of Nursing on 3/10/19 on following care plan interventions. Activity Assistants will provide nail care for all residents requiring assistance weekly and document on nail care log. Certified	

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F 656	Continued From page 2 was consistent with residents' rights that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were outlined in the resident's comprehensive assessment. Review of the "Policy Explanation and Compliance Guideline" revealed the care plan process would include an assessment of the resident's strengths, needs, personal, and cultural aspects to develop measurable objectives and timeframes. The comprehensive care plan would be developed within seven (7) days of the completion of the "Minimum Data Set (MDS)." Triggered areas on the MDS and other factors identified by the interdisciplinary team would also be addressed in the care plan. The guidelines further revealed the comprehensive care plan would describe the services that would be provided to attain or maintain the resident's highest physical, mental, and psychosocial well-being. Further review revealed the comprehensive care plan would be reviewed and revised by the team after each comprehensive and quarterly MDS assessment. The comprehensive care plan would use the objectives to monitor the resident's progress. Interview with the Administrator on 03/07/19 at 2:15 PM revealed the facility did not have a specific policy on implementation of the care plan interventions. Resident #42 Review of the "Comprehensive Care Plan" for Resident #42, undated, revealed a problem for being at high risk for infection which was related to an indwelling urinary catheter and urine retention. One (1) of the interventions directed the staff to wash the indwelling urinary catheter with	F 656	Nursing Assistants (CNA s) will clean nails of each resident that requires assistance while bathing and as needed. CNA s or licensed nurses will trim each resident s nails weekly or as needed. Activity Assistants were in-serviced on providing and documenting weekly nail care on 3/8/19 by the Activity Director. The Director of Nursing in-serviced all nursing staff on 4/10/19 on cleaning nails with bath, trimming nails weekly and nail care as needed. The Activity Director will audit nail logs weekly for completion and take corrective action as needed. The Social Services Director will make rounds weekly, observe resident nails to ensure care plan is followed and document any concerns. The Social Service Director will report any concerns with nail care to the Director of Nursing. A task has been added in the electronic point of care system for Certified Nursing Assistants (CNAs) to document foley catheter care. CNAs will perform foley catheter care each shift and document the foley catheter care in the electronic point of care system. All licensed nurses and CNAs were in-serviced on 4/10/19 by the Director of Nursing on providing foley catheter care each shift and documenting in the electronic point of care system. The Infection Preventionist or Care Plan Coordinator will audit records of all residents with foley catheters weekly beginning 4/11/19 to ensure foley catheter care has been documented each shift and ensure care plan is being followed, document findings and take corrective action as needed. The Care Plan	

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F 656	Continued From page 3 soap and water every shift and as needed. Observation of Resident #42 on 03/04/19 at 8:40 AM, revealed he was in his room lying on the bed. An indwelling urinary catheter was draining to bedside drainage and the urine was medium yellow with no sediment. Interview on 03/06/19 at 10:58 AM, with Resident #42, revealed the staff may have cleaned the catheter tubing when he was first admitted but, the tubing had not been cleaned since then. Interview on 03/06/19 at 11:00 AM, with Registered Nurse (RN) 5, revealed the nurses and the Certified Nursing Assistants (CNA's) both perform catheter care. The CNA's mark in the "kiosk" (a remote computer station) that the catheter care was done, and the nurses document on the "Treatment Administration Record (TAR)" showing catheter care had been completed. RN #5 further revealed the CNA's could also just tell the nurse catheter care was completed. RN #5 stated if the documentation on the TAR was blank then that meant the catheter care had not been performed as ordered. Record review of the February 2019 TAR revealed 13 blanks for day shift which indicated catheter care may not have been performed. Record review of the March 2019 TAR, revealed blanks on March 1, 2019 and March 5, 2019, which indicated catheter care may not have been done. During interview with Resident #42 on 03/07/19 at 9:20 AM, after observation of catheter care, the resident stated the staff had not done catheter care since he was admitted. He stated they may	F 656	Coordinator reviewed all resident Care Plans on 4/11/19 to ensure foley catheter and nail care were addressed in the plan of care. The Care Plan Coordinator or Quality Assurance Nurse will review 5% of resident care plans monthly beginning 4/11/19 to ensure care plan is being followed. 4.The Activity Director and Social Services Director will report findings from weekly nail care audits to the Quality Assurance and Assessment Committee (QAA)/ Quality Assessment and Performance Improvement Committee (QAPI) monthly. The QAA/QAPI committee will review data from weekly nail care audits and revise the corrective action plan as necessary. The Infection Preventionist will report findings from weekly audits of residents with foley catheters to the Quality Assurance and Assessment (QAA) Committee/ Quality Assessment and Performance Improvement (QAPI) Committee monthly. The QAA/QAPI Committee will review data from weekly audits of residents with foley catheters and revise corrective action plan as needed.	

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F 656	Continued From page 4 have flushed the catheter, but they had not cleaned it before. Interview on 03/07/19 at 9:45 AM, with CNA #9, who provided care to Resident #42 that day, revealed the CNA's do catheter care every two (2) hours, however she stated Resident #42 did not have a catheter. CNA #9 revealed she had not been in to provide care to Resident #42 since she had come on the shift at 7:00 AM. Observation further revealed CNA #9 reviewed the care plan in the "kiosk", twice, and still stated Resident #42 did not have a catheter, even though the care plan had a problem listed for catheters. CNA #9 stated the area for peri care was where they documented a check which indicated the peri care and catheter care had been completed. Interview with CNA #9 revealed she had not looked at Resident #42's care plan that morning. Interview on 03/07/19 at 10:03 AM, with RN #2/Quality Assurance (QA) Nurse/Infection Preventionist (IP), revealed it would be anyone's guess as to whether the catheter care was done in February 2019, on the dates where the documentation was not signed as completed. She further revealed the failure to do catheter care for Resident #42 put him more at risk for infection. Interview with RN #17/Minimum Data Set (MDS)/Care Plan (CP) Coordinator, on 03/07/19 at 2:00 PM, revealed Resident #42 had a care plan for catheter care and the care plan should be followed. She further revealed she expected the care plan to be updated each time something happened with a resident. RN #17/MDS/CP Coordinator stated if a resident developed a pressure sore, then a care plan should be	F 656		

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F 656	Continued From page 5	F 656		

developed for the pressure sore and interventions should be implemented.

Review of the "Admission Sheet" revealed Resident #42 was admitted on 01/02/19, with diagnoses of Calculus of Ureter, Diabetes Mellitus type 2, and, Depressive Disorder.

Review of Resident #42's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/16/19, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The MDS indicated Resident #42 had an indwelling urinary catheter.
Resident #14
Review of the 12/21/19 "Certified Nursing Assistant (CNA) Plan of Care", noted: "Daily cleaning and weekly trim of nails."

Observations on 03/04/19 at 10:00 AM and 3:30 PM, on 03/05/19 at 9:30 AM and 4:00 PM, and on 03/06/19 at 10:00 AM and 2:53 PM, revealed Resident #14 was lying in her bed and had dark brown material under her finger nails.

During an observation on 03/06/19 at 10:00 AM, with CNA #16, Resident #14 was lying in bed and CNA #16 confirmed Resident #14 had dirty nails that required a trim and cleaning.

During an interview on 03/06/19 with CNA #16 at 10:12 AM, she stated she was assigned to Resident #14 on 03/05/19 and 03/06/19. CNA #16 stated that although she provided personal care to Resident #14 on 03/05/19 and 03/06/19, and the resident was compliant with personal care, she did not trim or clean Resident #14's nails.

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F 656	Continued From page 6 Observations and interviews on 03/06/19 at 11:35 AM, with the Director of Nurses (DON), and at 3:53 PM with the Administrator, confirmed Resident #14 was lying in her bed with brown material under her nails. The "Profile" found in Resident #14's electronic medical record (EMR), indicated Resident #14 was admitted to the facility on 04/08/16, with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and Intracranial Hemorrhage. Resident #14's significant change MDS assessment, with an ARD of 12/26/18, indicated Resident #14's Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated Resident #14 had moderate cognitive impairment, required assistance of one (1) to two (2) staff members for personal care, and had no behaviors related to rejection of care. During an interview with the RN #17/MDS/CP Coordinator, on 03/06/19 at 8:54 PM, she stated Resident #14 had a decline in mental status since the December 2018 MDS assessment. RN #17/MDS/CP Coordinator stated she was not able to complete the BIMS on Resident #14 on 03/06/19, related to Resident #14's confusion.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		4/12/19

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F 657	Continued From page 7 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise the care plans for one (1) of 21 sampled residents, Resident #14. Resident #14's care plan was not updated to include interventions for a known unsafe behavior. Findings include: Record review of the facility's policy titled, "Comprehensive Care Plans," dated September 2018, revealed the comprehensive care plan would be reviewed and revised by the team after each comprehensive and quarterly MDS assessment. The comprehensive care plan would use the objectives to monitor the resident's	F 657	1.The care plan for Resident # 43 was revised on 3/6/19 by the Care Plan Nurse to include potential for unsafe behaviors related to the misuse of personal items. 2.All residents with severe cognitive impairment that exhibit signs of unsafe behaviors in regard to misuse of personal care items have the potential to be affected.2 of 22 Residents were identified to have the potential to be affected. 3.All Licensed Nurses, Certified Nursing Assistants (CNAs), Housekeeping/Laundry staff and Activity Assistants were in-serviced by the Social Worker on 4/4/19 regarding safe access to personal items. All Licensed Nurses	

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F 657	Continued From page 8 progress. Resident #43 Resident #43's "Care Plan", located in the EM and dated 02/11/19, indicated, "High risk for altered moods, behaviors, anxiety, and entering other residents' rooms." The Care Plan did not document issues with unsafe acts by Resident #43, such as thinking a bottle of soap was water to drink and there were no new interventions to address this activity. The 01/18/19 "Nurse's Note" documented: "This nurse in resident's room making rounds when resident came out of bathroom. Resident had a bottle that had soap in it, in her hands twisting the lid back on it. This nurse asked resident what she was doing with the bottle. Resident stated, "It's my water bottle to drink." This nurse explained to resident that it is a soap bottle, and not a good idea to drink out of it. This nurse asked resident if she drank anything from the bottle. Resident stated, "No." This nurse showed resident her water pitcher/cup and told her there is water in it and if she needed more to let staff know. Resident got upset and started to cry and stated, Why do I always do things like this." This nurse consoled resident and was able to calm her down and took her to the dining room. Resident on antibiotic for Urinary Tract Infection. Confusion noted. During an interview with the Registered Nurse (RN) #17 MDS/CP Coordinator, on 03/06/19 at 8:54 AM, she stated each team member was responsible for revising a care plan when indicated. The MDS Coordinator said she was not aware of the 01/18/19 incident with the soap; the incident was not discussed at the care plan meeting in January 2019, and therefore, she did	F 657	were in-serviced by the Director of Nursing on 4/10/19 regarding documenting and reporting unsafe behaviors and revising resident care plans to include unsafe behaviors. All residents with severe cognitive impairment were assessed for the potential to misuse personal items by the Care Plan Nurses on 4/11/19 and 2 out of 22 residents were identified at risk to misuse personal care items. The care plan for each resident identified at risk for misuse of personal care items have been updated and personal items for residents identified to have the potential for unsafe behaviors regarding the misuse of personal care items will be stored out of reach. CNA s will check rooms of residents identified at risk for misuse of personal items to ensure personal items are stored out of reach and document in the point of care system. Administrative Nurses will perform environmental safety rounds weekly beginning 4/11/19 to observe for potential environmental hazards, take corrective actions as needed and document findings. The Quality Assurance Nurse or Care Plan Coordinator will audit 5% of resident records monthly to ensure care plans are revised as changes occur and document findings. 4.The Director of Nursing will report findings from weekly environmental safety rounds to the Quality Assurance and Assessment (QAA)/ Quality Assessment and Performance Improvement (QAPI) Committee monthly. The Quality Assurance Nurse will report findings from record audits to the QAA/QAPI Committee	

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F 657	Continued From page 9 not revise Resident #43's care plan. During interview on 03/06/19, with the Director of Nurses (DON) at 9:46 AM, she acknowledged Resident #43's current care plan did not reflect the potential for issues with soap etc. and did not have interventions to ensure Resident #43's safety. During an interview with Licensed Practical Nurse (LPN) #22, on 03/07/19 at 2:36 PM, she stated Resident #43 had Dementia and confusion. LPN #22 stated she observed Resident #43 twisting the cover back on a bottle of soap that had a pump on it. LPN #22 stated there was no resident name on the bottle and she had no idea where Resident #43 obtained the soap bottle. LPN #22 stated Resident #43 told her she was filling up her water bottle. LPN #22 stated when asked, Resident #43 told her she did not drink anything from the soap bottle and she took the soap bottle from Resident #43. LPN #22 stated she documented the incident in the nurse's note and notified the certified nurse aides on the unit regarding the incident. LPN #22 stated Resident #43 had no adverse effects. LPN #22 stated she notified the oncoming nurse. LPN #22 stated she did not revise Resident #43's care plan. The "Profile" found in Resident #43's EMR, indicated Resident #43 was admitted to the facility on 11/28/14, with diagnoses which included Dementia with behavioral disturbance and Anxiety Disorder. Resident #43's annual MDS, with an ARD of 10/26/18, indicated the resident had a BIMS score of 5 out of 15, which indicated severe cognitive impairment. Resident #43 required	F 657	monthly. The QAA/QAPI Committee will review data from weekly environmental safety rounds and monthly record audits monthly and revise the corrective action plan as needed.	

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F 657	Continued From page 10 supervision and assistance with mobility and set up help with eating. During interview with RN #17/MDS/CP Coordinator, on 03/07/19 at 2:30 PM, she stated she expected care plans and interventions to be developed as resident needs were identified.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide fingernail care for one (1) of 21 sampled residents, Resident #14, per the facility's "Nail Care" policy and Resident #14"s plan of care. Findings include: The facility's policy titled, "Nail Care," dated 2018, read, "Routine cleaning and inspection of nails will be provided during activities of daily living (ADL) care on an ongoing basis." Observations on 03/04/19 at 10:00 AM and 3:30 PM; on 03/05/19 at 9:30 AM and 4:00 PM; and on 03/06/19 at 10:00 AM, revealed Resident #14 was lying in her bed and had dark brown material under her fingernails. The 12/21/18 "Certified Nurse Aide (CNA) Plan of Care" indicated "Daily cleaning and weekly trim of nails." Resident #14's "Self-Care and Hospice	F 677	1.The Medicare Coordinator provided nail care for Resident #14 on 3/6/19. 2.All residents that require assistance with activities of daily living have the potential to be affected. 3.Activity Assistants will provide nail care for all residents requiring assistance weekly and document on nail care log. Certified Nursing Assistants (CNA s) will clean nails of each resident that requires assistance while bathing and as needed. CNA s or Licensed Nurses will trim each resident s nails weekly or as needed. Activity Assistants were in-serviced on providing and documenting weekly nail care on 3/8/19 by the Activity Director. The Director of Nursing in-serviced all nursing staff on 4/10/19 on cleaning nails with bath, trimming nails weekly and nail care as needed. The Activity Director will audit nail logs weekly beginning 4/11/19 for completion and take corrective action	4/12/19

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F 677	Continued From page 11 Care Plans" dated 01/04/19, documented, "Keep resident well-groomed." During interviews on 03/05/19, with Licensed Practical Nurse (LPN) #15 at 10:04 AM; CNA #14 at 9:55 AM; and CNA #13 at 10:57 AM; and on 03/06/19 with CNA #16 at 10:12 AM; and with CNA #18 at 9:26 AM, they said the staff provided nail care to Resident #14 during shower days and as needed (prn). CNA #14 and CNA #18 stated Resident #14 was occasionally resistant with care and when re-approached later in the shift, was always agreeable to nail care. CNA #13 and CNA #16 stated they never had issues providing nail care to Resident #14. During an interview with the RN #17/Minimum Data Set (MDS)/Care Plan (CP) Coordinator, on 03/06/19 at 8:54 AM, she stated Resident #14 had a decline in mental status since her December 2018 "MDS" assessment. She further stated she was not able to complete a "BIMS" on Resident #14 on 03/06/19, related to the resident #14's confusion. During an observation with CNA #16 on 03/06/19 at 10:00 AM, CNA #16 confirmed Resident #14 had dirty fingernails that required trimming and cleaning. CNA #16 stated she was assigned to Resident #14 on 03/05/19 and 03/06/19; Resident #14 was not resistive to care, and although she provided personal care to Resident #14, she did not provide nail care to Resident #14. CNA #16 stated she would immediately trim and clean Resident #14's nails. During an observation and interview on 03/06/19 at 11:35 AM, with the Director of Nurses (DON)	F 677	as needed. The Social Services Director will make rounds weekly beginning 4/11/19, observe resident nails to ensure care plans are being followed and document any concerns. The Social Service Director will report any concerns with nail care to the Director of Nursing weekly. 4.The Activity Director and Social Services Director will report findings from weekly audits to the Quality Assurance and Assessment Committee (QAA)/ Quality Assessment and Performance Committee (QAPI) monthly. The QAA/QAPI committee will review data from weekly nail care audits and revise the corrective action plan as necessary.	

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F 677	Continued From page 12 and the Administrator at 3:53 PM, they acknowledged Resident #14 was lying in her bed with brown material under her fingernails and stated the staff did not follow the facility's "Nail Care" policy. Observations and interviews on 03/06/19 at 3:53 PM with the Administrator, confirmed Resident #14 was lying in her bed with brown material under her fingernails. The "Profile" found in Resident #14's electronic medical record (EMR), indicated Resident #14 was admitted to the facility on 04/08/16, with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and Intracranial Hemorrhage. Resident #14's significant change "Minimum Data Set (MDS)", with an "Assessment Reference Date (ARD)" of 12/26/18, indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15, which indicated moderate cognitive impairment. Resident #14 required assistance of one (1) to two (2) staff members for personal care and hygiene, and had no behaviors related to rejection of care.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		4/12/19

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F 689	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the environment remained as free of accident hazards as is possible and to provide adequate supervision to prevent accidents for one (1) of one resident, Resident #43, in a sample of 21 residents. Findings include: The "Profile" found in Resident #43's electronic medical record (EMR), indicated Resident #43 was admitted to the facility on 11/28/14, with diagnoses which included Dementia with behavioral disturbance and Anxiety Disorder. The annual "Minimum Data Set" (MDS), with an "Assessment Reference Date" (ARD) of 10/26/18, indicated Resident #43's "Brief Interview for Mental Status (BIMS)" score of 5 out of 15, which indicated severe cognitive impairment. Resident #43 required supervision and assistance with mobility and set up help with eating. The 01/18/19, "Nurse's Note" documented: "This nurse in resident's room making rounds when resident came out of bathroom. Resident had a bottle that had soap in it, in her hands twisting the lid back on it. This nurse asked resident what she was doing with the bottle. Resident stated, "It's my water bottle to drink." This nurse explained to resident that it is a soap bottle, and not a good idea to drink out of it. This nurse asked resident if she drank anything from the bottle. Resident stated, "No." This nurse showed resident her water pitcher/cup and told her there is water in it and if she needed more to let staff know.	F 689	1.The care plan for Resident # 43 was revised on 3/6/19 by the Care Plan Nurse to include potential for unsafe behaviors related to the misuse of personal items. Resident # 43 has had no other incidents of unsafe behavior. 2.All resident with severe cognitive impairment that exhibit signs of unsafe behaviors in regard to misuse of personal care items have the potential to be affected. 2 of 22 Residents were identified to have the potential to be affected. 3.All licensed nurses, Certified Nursing Assistants (CNAs), Housekeeping/Laundry staff and Activity Assistants were in-serviced by the Social Worker on 4/4/19 regarding safe access to personal items. All Licensed Nurses were in-serviced by the Director of Nursing on 4/10/19 regarding documenting and reporting unsafe behaviors and revising resident care plans to include unsafe behaviors. All residents with severe cognitive impairment were assessed for the potential to misuse personal items by the Care Plan Nurses on 4/11/19.2 out of 22 residents were identifies at risk for misuse of personal care items. The care plan for each resident identified at risk for misuse of personal care items have been updated and personal items for residents identified to have the potential for unsafe behaviors regarding the misuse of personal care items will be stored out of reach. CNA s will check rooms of residents identified at risk for misuse of personal items to	

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F 689	Continued From page 14 Resident got upset and started to cry and stated, "Why do I always do things like this." This nurse consoled resident and was able to calm her down and took her to the dining room. Resident on antibiotic for urinary tract infection. Confusion noted." During interviews on 03/05/19 with Licensed Practical Nurse (LPN) #19 at 10:42 AM; Certified Nurse Assistant (CNA) #13 at 10:48 AM; and on 03/06/19 with CNA #18 at 9:17 AM, Director of Nurses (DON) at 9:46 AM, with Registered Nurse (RN) #20 at 11:10 AM, and with LPN #21 at 1:30 PM, they stated they were not aware of the soap bottle issue with Resident #43. During an interview with the Registered Nurse (RN) #17/Minimum Data Set (MDS)/Care Plan (CP) Coordinator, on 03/06/19 at 8:54 AM, she stated each team member was responsible for revising a care plan when indicated. She stated she was not aware of the incident with the soap on 01/15/19; the incident was not discussed at the care plan meeting in January 2019, and therefore, she did not revise Resident #43's care plan. During an interview with LPN #22 on 03/07/19 at 2:36 PM, she stated Resident #43 had dementia and confusion. LPN #22 stated she observed Resident #43 twisting the cover back on a bottle of soap that had a pump on it. LPN #22 stated there was no name on the bottle and she had no idea where Resident #43 obtained the soap bottle. LPN #22 stated Resident #43 told her she was filling up her water bottle. LPN #22 stated Resident #43 told her she did not drink anything from the soap bottle and she took the soap bottle from Resident #43. LPN #22 stated she	F 689	ensure personal items are stored out of reach and document in the point of care system. Administrative Nurses will perform environmental safety rounds weekly beginning 4/11/2019 to observe for potential environmental hazards, take corrective actions as needed and document findings. The Quality Assurance Nurse or Care Plan Coordinator will audit 5% of resident records monthly to ensure care plans are revised as changes occur and document findings. 4.The Director of Nursing will report findings from weekly environmental safety rounds to the Quality Assurance and Assessment (QAA)/ Quality Assessment and Performance Improvement (QAPI) Committee monthly. The Quality Assurance Nurse will report findings from record audits to the QAA/QAPI Committee monthly. The QAA/QAPI Committee will review data from weekly environmental safety rounds and monthly record audits monthly and revise the corrective action plan as needed.	

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F 689	Continued From page 15 documented the incident in the nurse's note and notified the certified nurse aides on the unit regarding the incident. LPN #22 stated Resident #43 had no adverse effects. LPN #22 stated she notified the oncoming nurse and could not recall if she documented the information on the 24 hour report log. LPN #22 stated she did not revise Resident #43's "Care Plan." Resident #43's "Care Plan", located in the EMR, dated 02/11/19, documented, "High risk for altered moods, behaviors, anxiety, and entering other residents' rooms." The "Care Plan" did not document issues with unsafe acts by Resident #43, such as thinking a bottle of soap was water to drink and there were no interventions to address this activity (to help prevent other events). During interview with the DON on 03/06/19 at 9:46 AM, she stated Resident #43's current "Care Plan" did not reflect the potential for issues with soap, etc. and did not have interventions to ensure Resident #43's safety. The DON said no one notified the staff regarding the incident, with the exception of LPN #22's notification of her staff on 01/18/19.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		4/12/19

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F 690	Continued From page 16 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide catheter care per the facility policy for one (1) of one (1) sampled resident, Resident #42, with an indwelling urinary catheter. The facility had three (3) residents with indwelling urinary catheters. Resident #42 was to have catheter care done every shift and this was not provided. Findings include:	F 690	1.Resident # 42 did not develop an infection as a result of inconsistent foley catheter care. Resident # 42 was assessed on 4/7/19 by the Director of Nursing for signs and symptoms of infection, Resident #42 did not exhibit signs or symptoms of infection. Resident #42 s foley catheter was discontinued on 3/22/19. 2.All residents with foley catheters have the potential to be affected.	

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F 690	Continued From page 17 Review of the policy titled, "Catheter Care Policy", dated October 2018, revealed the purpose of the policy was to prevent catheter-associated Urinary Tract Infections (UTIs). The "Policy Explanation and Compliance Guidelines" directed the staff to perform catheter care every shift and as needed and it was to be done by the nursing assistant. Observation of Resident #42 on 03/04/19 at 8:40 AM, revealed he was in his room lying on the bed. An indwelling urinary catheter was draining to bedside drainage and the urine was medium yellow with no sediment. Resident #42 stated the facility staff had flushed his catheter when he was first admitted to the facility, but they had not done that in a long time and they did not clean the catheter tubing. Review of the "Admission Sheet" on the hard copy chart, revealed the facility admitted Resident #42 on 01/02/19, with diagnoses which included Calculus of Ureter, Diabetes Mellitus type 2, and Depressive Disorder. Review of the admission "Minimum Data Set (MDS)", with an "Assessment Reference Date (ARD)" of 01/16/19, indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated Resident #42 was cognitively intact. Resident #42 had an indwelling urinary catheter. Review of the "Comprehensive Care Plan" from the electronic medical record (EMR) which was undated, revealed a problem of, "Being at high risk for infection which was related to indwelling urinary catheter and urine retention." One of the interventions directed the staff to wash the indwelling urinary catheter with soap and water	F 690	3.A task has been added in the electronic point of care system for Certified Nursing Assistants (CNAs) to document foley catheter care. CNAs will perform foley catheter care each shift and document the foley catheter care in the electronic point of care system. All Licensed Nurses and CNAs were in-serviced on 4/10/19 by the Director of Nursing on providing foley catheter care each shift and documenting in the electronic point of care system. The Infection Preventionist or Care Plan Coordinator will audit records of all residents with foley catheters weekly to ensure foley catheter care has been documented each shift beginning 4/11/19 , document findings and take corrective action as needed. . 4.The Infection Preventionist will report findings from weekly audits of residents with foley catheters to the Quality Assurance and Assessment (QAA) Committee/ Quality Assessment and Performance Improvement (QAPI) Committee monthly. The QAA/QAPI Committee will review data from weekly audits of residents with foley catheters and revise corrective action plan as needed.	

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F 690	Continued From page 18 every shift and as needed. Observation on 03/05/19 at 10:20 AM, revealed Resident #42 was sitting up in his wheelchair and his indwelling urinary catheter was in a bag but, was lying on the floor and he had run over the tubing with his wheelchair. Interview with Certified Nursing Assistant (CNA) #12 on 03/05/19 at 10:20 AM, revealed Resident #42 had had gone to the bathroom and the catheter had probably fallen off the chair when he got back to his chair. Interview on 03/06/19 at 10:58 AM, with Resident #42, revealed staff had flushed his indwelling urinary catheter when he first came to the facility, but they had not done that in a long time and they did not clean the catheter tubing anymore. Interview on 03/06/19 at 11:00 AM, with Registered Nurse (RN) #5, revealed the nurses and the CNA's both provided catheter care. The CNA's mark in the "kiosk" (a remote computer station) that the catheter care was done, and the nurses document on the "Treatment Administration Record (TAR)" showing catheter care had been completed. RN #5 further revealed the CNA's could also just tell the nurse catheter care was completed. RN #5 stated if the documentation on the TAR was blank then that meant the catheter care had not been performed as ordered. Review of the February 2019 TAR, revealed 13 blanks for day shift which indicated catheter care may not have been performed. Review of the March 2019 TAR, revealed blanks on March 1, 2019 and March 5, 2019, which indicated catheter care may not have been done.	F 690		

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F 690	Continued From page 19 On 03/06/19 at 11:15 AM, catheter care was observed for Resident #42. CNA #11, who was Resident #42's CNA for that day, CNA #13 and the CNA's instructor were in the room. CNA #13 instructed CNA #11 with the steps to follow as CNA #11 performed the catheter care. During the catheter care, Resident #42 laughed and stated, "This is a three-ring circus." Interview on 03/06/19 at 1:05 PM, after completion of the catheter care, CNA #11 stated she cleaned the indwelling urinary catheter every time she changed Resident #42 and it did not matter if he had a bowel movement or not. She revealed there was no place separate on the "kiosk" that she charted in, so she put the catheter care under peri care and told the nurses she had completed it. During interview on 03/07/19 at 9:20 AM, with Resident #42, he stated he had never had catheter care done like it was done yesterday, and staff had only flushed his catheter when he first came in. Resident #42 stated it was like a training session and he believed they were faking it. Interview on 03/07/19 at 9:45 AM, with CNA #9, who provided care to Resident #42 that day, revealed the CNA's do catheter care every two (2) hours, however Resident #42 did not have a catheter. CNA #9 revealed she had not been in to provide care to Resident #42 since she had come on shift at 7:00 AM. Observation further revealed CNA #9 reviewed the care plan in the "kiosk", twice, and still stated Resident #42 did not have a catheter even though the care plan had a problem listed for catheters. CNA #9 stated the area for peri care was where they documented a	F 690		

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F 690	Continued From page 20 check, which indicated the peri care and catheter care had been completed. Interview with CNA #9 revealed she had not looked at the care plan that morning for Resident #42. Interview with RN #2/Quality Assurance (QA) Nurse/Infection Preventionist (IP), on 03/07/19 at 10:03 AM, revealed she had done in-services with the CNA's about indwelling urinary catheter care. RN #2/QA/IP, revealed it was the responsibility of the nurses to make sure the catheter care was being done and documented. RN #2/QA/IP stated for the blanks in documentation for February and March 2019, you could only guess as to whether catheter care had been done or not. She revealed it was an increased risk for infection for the resident if catheter care was not done. She further revealed the CNA's should check the care plan at the beginning of their shift to ensure correct care was done. Interview with the Director of Nursing (DON), on 03/07/19 at 11:27 AM, revealed CNAs were to do catheter care and then the nurse signed it as completed on the TAR. The nurse should ask the staff before the end of the shift to ensure accurate documentation. The DON further revealed peri care and catheter care were two different care areas. The "Point of Care" (POC) in the "kiosk" did not address catheter care separately therefore, the CNA should tell the nurses they have completed the catheter care. The DON revealed that technically if catheter care was not documented as done then it was not done. The DON stated catheter care should be done every shift and, as needed, if soiled with bowel movement The DON further revealed failure to do catheter care could put the resident at risk for bacteria to accumulate on the tubing	F 690		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 21 and an infection could occur.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING **01 - GREENBRIAR NURSING CENTER** B. WING _____	**03/06/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222		3/28/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/10/2019

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K 222	Continued From page 1 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly maintain patient sleeping room doors as directed by NFPA 101 section 19.2.2.2.5. This deficiency affected 34 of the 90 residents in the facility on the day of survey. Findings include:	K 222	1.The doors on Beach Avenue, Forrest Drive and the front entrance were repaired by ADS Systems on 3/6/19. The Administrator and Maintenance Director verified that all locked exit doors released upon activation of the fire alarm after repairs were complete on 3/6/19. 2.All residents have the potential to be	

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K 222	Continued From page 2 On March 6, 2019 at 11:25 AM, observation revealed exit doors on the Beach Avenue Wing, Forrest Drive Wing, and the Front Entrance Area did not release upon activation of the fire alarm system. Observation also revealed the electrical power to these exit doors was turned off prior to the conclusion of the survey.	K 222	affected. 3.The Assistant Administrator or designee will check all locked exit doors in conjunction with fire drills monthly to ensure release of all locked exit doors upon activation of the fire alarm, take immediate action as necessary and document on log. 4.The Assistant Administrator will report any issues identified during monthly fire drills related to locked exit doors releasing upon activation of the fire alarm and any actions taken to the Quality Assessment and Assurance (QAA) Committee / Quality Assessment and Performance Improvement (QAPI) Committee monthly. The QAA/QAPI Committee will revise the corrective action plan as needed.	

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 3/6/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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